

STATE PLAN FOR MEDICAL ASSISTANCE
UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Program	Limitations
Services that require preauthorization	<ol style="list-style-type: none"> 1. All services and items provided under this chapter require pre-authorization with the exception of replacement items costing less than \$5 for components of complete set ups. 2. Pre-authorization is issued when: <ol style="list-style-type: none"> a. Program procedures are met; b. Program limitations are met; and c. The Provider submits to the Department adequate documentation demonstrating that the service to be pre-authorized is necessary and appropriate. "Necessary" means directly related to diagnostic, preventive, curative, palliative, or rehabilitative treatment. "Appropriate" means an effective service that can be provided, taking into consideration the particular circumstance of the recipient and the relative cost of any services which could be used to the same purpose. 3. The prescriber shall submit requests for pre-authorization in writing using the form designated by the Department. 4. Verbal pre-authorization may be requested by the prescriber in emergency situations or to expedite hospital discharge. In both cases the prescriber must have initiated a written request for pre-authorization on the appropriate form, which shall <ol style="list-style-type: none"> a. Then be transmitted immediately to the Department with the indication that verbal approval has been received, and from whom; and b. Be received within 15 days from the date the verbal pre-authorization is issued. 5. Verbal pre-authorization is valid for a maximum of 30 days contingent on No. 4 above and the recipient's continuing eligibility. 6. Written pre-authorization is valid for a period to be determined by the Program but not to exceed a maximum of 365 days beginning with the date of issue by the Program, and is contingent on the recipient's continuing eligibility. 7. Pre-authorization normally required by the Program is waived when the services are covered and approved by Medicare. However, if the entire or any part of a claim is rejected by Medicare, and the claim is referred to the Program for payment, payment will be made for services covered by the

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Program

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Program only if authorization for those services
has been obtained before billing. Non-Medicare
claims require preauthorization according to
No. 1-6 above.

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Supercedes
TN# _____

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